MassHealth Application for Personal Care Attendant (PCA) Services

The PCA Agency is to complete and submit this application to MassHealth with all relevant documentation, including the request for prior approval. MassHealth may defer or deny incomplete applications.

Section I: Personal Care Agency

1	Agency Name:	2	Provider No.:

Section II: Consumer Information

3	Consumer Name:	4	Birth Date:	5	Age:
		6	Date of Evaluation: ☐Initial ☐Re-eval		
7	RID No.:	8	Site of Evaluation:		
9	Current Address: Telephone No.:	10	Address for Service Delivery: Telephone No.:		
11	Date of Initial Referral to PCA Agency: _____ Referral Source: _____	12	For new applicants, the event that precipitated the request for PCA services:		

Section III: Personal Care Attendant Services

13	Current PCA Schedule (Weekdays/Weekends):	14	Current PA No.: _____ Expiration Date: _____
15	Proposed PCA Schedule (Weekdays/Weekends:):		
16	Weekly Day/Evening PCA Hours Requested:	17	Weekly Night PCA Hours Requested:
18	Consumer's Legal Guardian's Name and Address:		Telephone No.:

19	Living Arrangement (check all that apply):	20	Lives with (check all that apply):
☐Lives with family ☐Transitional living ☐Foster home (specify) ☐Other, including other state-funded residential supports (specify):	☐Lives independently ☐DMR (specify)	☐Mother ☐Spouse ☐Children (number and ages: _____) ☐Siblings (number: _____) ☐Roommates (number: _____) ☐Other (specify: _____)	☐Father ☐Alone

21 Are individuals in the home currently providing personal care to consumer? ☐ Yes ☐ No

If yes, provide documentation to explain why caregiver cannot continue to provide care — for example, documentation from the caregiver's physician as to the caregiver's diagnosis, disabilities, and limitations.

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22 Is the consumer receiving or about to receive any home-based services? ☐ Yes ☐ No

If yes, check all applicable boxes in items a through f below, enter the dates of service or projected start date, and indicate the number of hours and daily schedule.

a Visiting Nurse ☐ Yes ☐ No Name of Agency: _____ Dates of Service or Start Date: _____ Number of Hours: _____ Schedule:	b Continuous Skilled Nursing (Private Duty Nurse) ☐ Yes ☐ No Name of Agency: _____ Dates of Service or Start Date: _____ Number of Hours: _____ Schedule:	c Respite ☐ Yes ☐ No If yes, identify funding source: _____ Name of Agency: _____ Dates of Service or Start Date: _____ Number of Hours: _____ Schedule:
d Other PCA or Homemaking Service (specify) ☐ Yes ☐ No Name of Agency: _____ Dates of Service or Start Date: _____ Number of Hours: _____ Schedule:	e Home Health Aide ☐ Yes ☐ No Name of Agency: _____ Dates of Service or Start Date: _____ Number of Hours: _____ Schedule:	f Other ☐ Yes ☐ No If yes, specify: _____ Name of Agency: _____ Dates of Service or Start Date: _____ Number of Hours: _____ Schedule:

23 Has consumer received PCA services from MassHealth in the past? ☐ Yes ☐ No

If yes, identify the following:

PCA Agency: Prior Auth. No.: Dates of Service:

24 Is anyone else in the home receiving PCA or home care services? ☐ Yes ☐ No

If yes, identify the following:

No. of people receiving services: _____ No. of hours of services received: _____

Names of people receiving services:

Schedule of all services in place:

MassHealth Application for Personal Care Attendant (PCA) Services (cont.)

Section IV: Medical History

25	Primary diagnosis affecting functional status and warranting PCA Services:	26	Date of Onset:
		27	Height:
		28	Weight:

29 List medical history relevant to application for PCA Services, such as diagnoses, hospitalizations, and surgical procedures, and attach any recent supporting documentation, such as discharge summaries, home health care plans, etc.

30 Is consumer registered with Massachusetts Commission for the Blind? ☐ Yes ☐ No

Is consumer receiving SSI/Blind benefits? ☐ Yes ☐ No

If answer is yes to both questions, submit this application to:

Massachusetts Commission for the Blind
48 Boylston Street
Boston, MA 02116-4718

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Section V: Out-of-Home Activities)

31 Indicate activities that result in the consumer leaving home by checking all applicable boxes in items a through i below and entering program name (provider, employer, or school), the dates of service or projected start date, the name and telephone number of contact person, and the daily schedule.

a ☐ Adult Day Health
Program: _____ Dates: _____
Contact: _____ Telephone No.: _____
Daily Schedule:

b ☐ Day Habilitation
Program: _____ Dates: _____
Contact: _____ Telephone No.: _____
Daily Schedule:

c ☐ Elder Services
Program: _____ Dates: _____
Contact: _____ Telephone No.: _____
Daily Schedule:

d ☐ DMH-Contracted
Program: _____ Dates: _____
Contact: _____ Telephone No.: _____
Daily Schedule:

e ☐ DMR-Contracted
Program: _____ Dates: _____
Contact: _____ Telephone No.: _____
Daily Schedule:

f ☐ DSS-Contracted Services
Program: _____ Dates: _____
Contact: _____ Telephone No.: _____
Daily Schedule:

g ☐ MRC-Contracted Services
Program: _____ Dates: _____
Contact: _____ Telephone No.: _____
Daily Schedule:

h ☐ Employment
Employer: _____ Dates: _____
Contact: _____ Telephone No.: _____
Daily Schedule:

i ☐ School
☐ Ch.766-Special Education
Program: _____ Dates: _____
Contact: _____ Telephone No.: _____
Daily Schedule:

j ☐ Other (specify)
Program: _____ Dates: _____
Contact: _____ Telephone No.: _____
Daily Schedule: